Nottinghamshire County Council

Policy Library Pro Forma

This information will be used to add a policy, procedure, guidance or strategy to the Policy Library.

Title: Reviewing Personal Budgets Guidance	
Aim / Summary: To set out the Council's commitment to reviewing personal budgets; to ensure that public money is being spent properly, and to ensure that service users and carers are in receipt of the support outlined in their community care assessment and support plan and that they are satisfied with the support they receive.	

Document type (please choose one)			
Policy		Guidance	x
Strategy		Procedure	

Approved by:	Version number: 8
Date approved:	Proposed review date:

Subject Areas (choose all relevant)

About the Council		Older people	x
Births, Deaths, Marriages		Parking	
Business		Recycling and Waste	
Children and Families		Roads	
Countryside & Environment		Schools	
History and Heritage		Social Care	x
Jobs		Staff	
Leisure		Travel and Transport	
libraries			

Author: Group Manager Older Adults Community Care	Responsible team: Personal Care and Support Older Adults
Contact number: 0115 9175800	Contact email: mark.mccall@nottscc.gov.uk
Please include any supporting documents	
1. Reviewing Personal Budgets Policy	

Nottinghamshire County Council

REVIEWING PERSONAL BUDGETS GUIDANCE

Contents:

1. INTRODUCTION

The purpose of this guidance is to:

- Ensure that the County Council's policy on reviewing personal budgets is consistently applied.
- Ensure that people currently having a managed service are offered a direct payment, so that they have the opportunity to have as much choice and control as possible over the support they receive.
- Help staff to make judgements about where service users should have 'face to face' reviews and where the other options can be applied.
- Ensure that service users with existing packages of care have a review of their support and that new "contacts" are not created for them on Framework.
- Clarify the role of reviewing officers and officers from Adult Care Financial Services (ACFS).
- Clarify when a minor amendment to a care package can be made without the need for a formal review.
- Clarify the position regarding reviews for carers.

Please note: Reviews can be undertaken by any appropriate social care worker from the Council. The term reviewing officer is used in this guidance to cover all possible roles.

1.1. Local policy and guidance

This staff guidance is based on the County Council's Reviewing Personal Budgets Policy.

For details of:

- The current eligibility threshold, see the staff guidance on Eligibility and Fair Access to Care Services.
- Assessment, support planning and reviews, see Assessment, Support Planning and Personal Budgets (staff guidance).

Staff must take account of the following when conducting reviews:

- Fairer contributions policy
- Use of Warnings in Social Care Records

Staff should also be aware of the guidance from the Care Quality Commission, "Key Lines of Regulatory Assessment" (KLORA) when conducting reviews of care home placements.

2. MINOR AMENDMENTS TO SUPPORT WITHOUT A REVIEW

2.1. Criteria

Minor amendments to a person's support can be made without a full review if the case meets any of the following criteria:

- The requested amendment to the existing support costs does not result in an increase to the overall personal budget of more than £75 per week

- The person's circumstances have changed, rather than their individual needs.
- The requested amendment is to previously identified and agreed support arrangements in the support plan or is temporary in nature.
- This could include the temporary unavailability of unpaid support.
- The person has had a face to face review within the last 12 months
- Information from adult care staff/provider suggests that the support package needs to increase to fulfil health and safety requirements.
- A predicted increase in needs has already been identified in the assessment

Before making an amendment workers must:

- Consider the criteria above using the last completed assessment and support plan or review to decide whether the request for an amendment meets the criteria or whether a review is needed.

- Ensure that service users/carers are aware of the proposed amendments and agree to them being made. Where there is no agreement, a review needs to be completed to resolve these issues.

If an Adult Access Team worker decides that a review is needed, he/she should send an update message to the appropriate district team to request this.

If the case is open to a district team and the worker has decided that it is not appropriate to make a minor amendment, the scheduled review can be brought forward and commenced, following discussion with the manager.

2.2. Procedure for making amendments

If the amendment does meet the criteria, workers must:

- Commence a new episode (from the New Episode list), called **Request Care Package Amendment.** This episode contains a form to outline the reason for the amendment and summarise the changes that are required. A commissioning outcome can then be sent to the worker who will be making those changes, which in most cases will be the reviewing officer themselves. The outcome will lead to a commissioning episode that will allow changes to be made to the care package, and contains tasks that allow the worker to ask other workers or teams make changes to the care package as appropriate. For example, a task can be sent to a service organiser team in the case of managed home care packages for physical disability and older adults' cases.

- Ensure that, where required, all amendments to existing packages are authorised by a an appropriate manager, unless the total value of the personal budget remains below £75 per week, in which case it can be authorised by the worker making the amendment.

- Choose the relevant outcome to ensure that a copy of the amended commissioned services is sent to ACFS (following team manager or self-authorisation). This will allow ACFS to amend the service user's contribution where necessary.

- Ensure that there is an appropriate review episode pending for the service user. It is not anticipated that making an amendment will necessitate bringing a scheduled review date forward, unless the amendment has been made on health and safety grounds or there has been a predicted increase in a service user's needs.

3. CONDUCTING A REVIEW FOR COMMUNITY SUPPORT

3.1. Checklist for use by staff (community reviews)

A checklist for staff to use when preparing for and conducting reviews for community support is included in appendix 1 of this guidance. Please use it.

3.2. The initial review

An initial review must be completed up to three months from the date of support being delivered. The purpose of the initial review is to check that the support provided is meeting the outcomes agreed in, and to make any amendments to, the original support plan. Subsequent reviews must take place at least annually.

Initial reviews are normally the responsibility of the original assessor. However, the central reviewing teams will complete initial reviews where:

- Home based support is in place with a provider, either as a managed personal budget or direct payment.
- The support being provided is **not** subject to complications, for example, a safeguarding investigation.

Currently the reviewing teams will complete all the initial reviews of support plans completed by assessors linked to START and this could apply more widely to all hospital and community based cases.

3.3. The annual or scheduled review

Send out standard letter, Appointment Letter Review. Annual reviews should be co-ordinated so the service user receives one review and enables workers to share information. Where a review is planned by an internal provider, the review should be co-ordinated with other workers involved with the person. The review will need to consider ***all*** the support or activities within the support

plan including services previously provided to the carer, not only their service area. This includes:

- Transport
- TV Licences
- Telephone Rental payments
- Day services
- Talking books

A community care review and support plan must be completed.

Following the organisational redesign and the restructuring of the teams in the Department, responsibility for annual or scheduled reviews will fall to teams responsible for assessing service users for their personal budgets. The only exception to this will be the reviewing of older adults in care home settings, which will remain the responsibility of the centralised reviewing team until March 2013

3.4. Unscheduled reviews

Although reviews are typically scheduled on an annual basis both carers and service users needs are subject to constant change. Often service users will request changes to their support as their needs change.These reviews are known as unscheduled reviews and are usually the responsibility of the team responsible for assessing service users. However, the central reviewing team will pick up straightforward cases from the service organisers or the Adult Access Team.

Please note: An unscheduled review should be commenced by identifying the scheduled review outcome, assigning this to yourself and starting work on it. After completing an unscheduled review **ALWAYS** remember to schedule the next annual review, which will typically be 12 months from the time the unscheduled review was completed. This will help to avoid duplication of effort within teams and keep the scheduled review list up to date.

If there is no scheduled review outcome, the Adult Access Team must create a review of community based services and send it to the apporpriate team or district. The only outcome available is to the team reviewing box. Therefore to avoid missing an urgent unscheduled review, the Adult Access Team should also send an updated message to the relevant team, which will act as an alert in the main team ‘in box’.

3.5. Reviewing Continuing Healthcare

The NHS has a mandatory responsibility to review all people who receive fully funded continuing health care or funding for nursing care at three months and then annually. This is referred to in the new "National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care", see point 8 of the executive summary or, for more detail, the section entitled Review.

Reviews of people receiving fully funded continuing healthcare or funding for nursing care should be linked to the reviews undertaken by colleagues in the NHS, where possible. Annual social care reviews should be done at the same time. This reduces the need for the service user to have multiple reviews and enables workers to share any relevant information. It also enables social care staff to consider the quality of the nursing care within a care home from the perspective of a qualified health professional.

A copy of the completed National Framework Decision Support Tool should be scanned into Framework after the review as part of the service user's record.

Where continuing healthcare funding is Fast Track (end of life) the service user will not be reviewed by adult care staff as they will no longer be receiving funding from Nottinghamshire County Council.

3.6. Reviewing Direct payments

Whilst guidance about reviewing direct payments is provided in section 13 of Direct Payments for Adults, including to a "Suitable Person", attention is drawn below to the different roles of Adult Care Financial Services and reviewing officers. This particularly applies to the responsibilities of reviewing officers in reviewing the finances of any direct payment arrangement.

The role of reviewing officers is to:

- Check bank statements etc at the annual review to see if the direct payment is not being used, if there is a high surplus in the accounts, if money is being mis-spent, or the service user's contribution is not being paid into account.
- Take action if there is a high surplus in the direct payment account. For further information, see section 12.2 of the staff guidance, Direct Payments for Adults, including to a Suitable Person.
- Investigate if evidence is found of the direct payment being mis-spent. This will include consideration of whether payments should be stopped and whether a safeguarding investigation is required.

The role of Adult Care Financial Services workers is to take the following action as a result of a review:

- Provide feedback to workers if any concerns have been raised during the audit process, for example: forms not returned; money not being used; high surplus in accounts; money being mis-spent; service user's contribution not being paid into the account.
- Request return of surplus/unspent money (over 6 weeks)
- Assist with cases of mis-spent funds
- Calculate and review the personal budget contribution

3.7. Reviewing carers' support

Whenever possible, a service user's personal budget review and a carer's review should be completed at the same time. This provides the clearest picture of the eligible need of the service user, the impact of caring on the carer and the support required for both. The carer's review may need to be held away from the person that is being cared for, to allow the carer to freely discuss their own level of need.

It is essential that main carers and people cared for are linked on Framework so that the services provided to both can be clearly identified. In the case of a disabled parent with a young carer, it is also essential that the service user is linked to the child record and set up as having parenting responsibilities.

See for following for more information:

- Carers: Completing an assessment of need-staff guidance
- Carers Personal Budgets – staff guidance
- Disabled Parents and Young Carers (supporting)
- Disabled Parents and Young Carers (additional funding)

3.8. Mental Capacity Act 2005

Staff must refer to the "Multi-Agency Joint Policy and Procedure on the Mental Capacity Act 2005" when conducting reviews with people who may lack the capacity to make decisions about matters that the review relates to. If there are doubts about the person's capacity and they are without friends or family to support them, they can be referred to an Independent Mental Capacity Advocate (IMCA) in certain circumstances. Details of the IMCA service in Nottinghamshire can be found in the Policy for Independent Advocacy.

The appropriate forms can be found in Framework if an assessment of capacity is needed:

1 Test of Capacity. This is contained in the 'Mental Capacity' episode (available from the new episode menu). Alternatively, if concerns regarding capacity arise during an assessment or review, the form is also available in those episodes - 'Community Care Assessment and Support Plan', 'Review – Community Based Services',' Review – Long Term Care'.
2. Best Interests Checklist. If the test of capacity results in the need for a Best Interests decision then the episode in which the capacity form is completed includes the outcome 'Person lacks capacity – Best Interests decision needed'. This leads to the 'Best Interests Checklist' episode that contains the Best Interests Checklist form.

Even if the person clearly has capacity to make the decision/s, it is good practice to cover the following points in all community care reviews:

- Does the person have a Lasting Power of Attorney?
- Does the person have a Court of Protection Appointed Deputy?
- Has the person made an Advance Decision to Refuse Treatment?

If the answer is yes to any of these questions, it is useful to briefly give or update details on Framework, where necessary.

3.9. Outcome of the review for community support

There are five possible outcomes from the review of community support. The expected response to each of these is set out below.

3.9.1. Needs can be met within existing personal budget

Where a service user's needs are being met with their existing personal budget, the budget must remain the same or it can be lowered if the person's outcomes can be met more cost effectively. Staff must always consider the options for meeting needs at a cost lower than the current support package, for example, daily living equipment or Telecare. Any changes to services must be reflected in the appropriate sections of the community care review and support plan.

Use standard letter, Post review – eligible, and choose appropriate option.

3.9.2. Unmet eligible needs identified

Where the review identifies unmet eligible needs workers must explore all options to meet needs and outcomes in the most cost effective way before the personal budget is increased. Consider a period of reablement if needs have changed.

Remember: Just because the review indicates that a person's eligible needs have increased **does not** necessarily mean their needs cannot be met at a cost *lower* than their current support.

Any changes to services must be reflected in the appropriate sections of the community care review and support plan.

Use standard letter, Post review – eligible, and choose appropriate option..

3.9.3. Needs can be met with a lower personal budget

The local authority has an obligation to meet a service user's needs in the most cost-effective way. If an individual can meet their needs with a lower personal budget, the service user should be moved to new arrangements as soon as is reasonable (and if it is possible to do so once pre-existing contractual arrangements have been taken into account). If the service user is not in agreement 4 weeks notice of the change will be given in writing.

Use standard letter, Post review – eligible, and choose appropriate option..

There will be cases where professional judgement is required to consider the need for a longer transitional period so that a change in support arrangements can be gradually introduced (perhaps with staggered reductions in the personal budget over a number of months). The plan should aim to ease the transition, ensure that the person can cope with their new settlement and allow for the careful monitoring of whether the new arrangements adequately meet eligible needs. Plans should include specific timescales in order to help planning and ensure that there is an agreement about the pace of the transition. This will require a team manager's approval and should only be considered where there are good reasons, for example where a service user has attended a day service for a number of years and this provides respite for the carer.

Funding should not be withdrawn until a viable alternative is identified. If no viable alternative can be found then existing levels of support and funding should be maintained until such time as a more cost-effective alternative has been brokered. Professional judgement is paramount.

Any changes to services must be reflected in the appropriate sections of the community care review and support plan.

3.9.4. Support to be withdrawn or reduced

If a service user is no longer eligible for all or part of their personal budget following review, four weeks notice must be given to withdraw or cease support. Managers have the discretion to extend this where appropriate (see above) and use their professional judgement.

If the review indicates that a person has a moderate risk in one of the domains in the assessment, the person may no longer be eligible for support in this area and the their personal budget may be reduced. This will leave people with needs that pose a substantial or critical risk to their independence receiving a personal budget. However, the guidance on eligibility, "Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care", states that councils should exercise caution when considering the withdrawal or reduction of support. The process below must be followed in these cases.

Where a person is no longer eligible for support in all or some areas, you must:

- Consider whether the service user's situation will get worse and their needs increase in the foreseeable future because of lack of support.
- Consider whether the support of any unpaid carers could break down in the future because of the lack of help.
- Ensure that the decision to cease or reduce support is scrutinised by the Group Manager before the final decision is made.
- Give information on the reasons for the withdrawal or reduction verbally and in writing, and offer an opportunity to comment on or make representations about the proposal, so that these can be taken into account before the decision is made.

- Confirm the eligibility decision in writing if a decision to cease the service is made. Use standard letter, Post review – ineligible service ended..
- Offer advice and guidance on other sources of help, including ways of purchasing comparable support where appropriate.
- Give a 4 week period of notice that the support is going to end.
- Offer information about the Council's complaints procedure.

If one or more services will continue to be provided, any changes to the care package must be reflected in the appropriate sections of the community care review and support plan.

For further information see the policy on Eligibility and Fair Access to Care Services

3.9.5. Service user has to meet the full cost of their support

Where a person continues to be eligible for support, but has to meet the full cost following a financial assessment, you must:

- Send out standard letter, Post review – self funders continue **or**
- If the person decides to make their own arrangements, send out standard letter, Post review – self funders ceased.

4. REVIEWS OF RESIDENTS IN CARE HOMES

Placements in care homes are not considered to be permanent until after the 6 to 8 week initial review. If the resident does not return home after eight weeks, but the potential for rehabilitation has been identified in the support plan, regular reviews of progress should be undertaken. This applies to placements both in the County and out of the County.

See, Charging for social care support – residential, for information about charges on a person's property.

4.1. Checklist for use by staff (residential reviews)

Reviewing officers should organise their reviews using the care home review checklist (SDS/CHRC). This can also be used to take notes during the review. The completed checklist should be used to complete relevant episodes in Framework. It can then be shredded.

4.2. Responsibility for undertaking reviews

Responsibility for reviews in care homes is as follows:

- Commissioning teams are responsible for the 6 to 8 week initial review of care home placements they have made.

- Currently the review of all long term placements for older adults without a personal budget will be the responsibility of the central reviewing team.

As soon as these service users are transferred onto a personal budget and a review scheduled, responsibility will transfer to the mainstream assessor teams after April 2013.

- Nursing home reviews ideally should be completed jointly with NHS colleagues. Where a social care review raises concerns in relation to the health needs of the resident then consideration should be given to completing a continuing care checklist and appropriate referrals made to GP or district nurse. A continuing care checklist should always be considered when reviewing people in residential or funded nursing care. NHS colleagues should be consulted for all nursing care reviews and, ideally, care programme approach reviews should also feed into the social care review; where possible both reviews should happen at the same time.

- Reviews of out of county placements remain the responsibility of Nottinghamshire County Council, but may be undertaken, if agreed, by the local social services department on Nottinghamshire's behalf. There will often be a fee, or reciprocal arrangements can be made. When Nottinghamshire staff undertake the review, they should see the resident face to face to assess the quality of care and to make sure that the resident is satisfied with the arrangements. Where the review is undertaken on behalf of Nottinghamshire it is the responsibility of the person requesting the review to upload this review onto Framework.

- Reviews of care home placements made locally by other authorities are the responsibility of the placing authority. If agreed by the team manager the review may be undertaken by Nottinghamshire's staff. The Department will charge a fee of £65 an hour up to a maximum charge of £165 for these reviews or reciprocal arrangements can be made where appropriate. The exception to this is where the review is requested on the basis of safeguarding concerns when Nottinghamshire will pass its review findings on to the relevant funding local authority without charge. See the staff guidance on safeguarding.

When considering an out of county review the team manager will decide if the distance to be travelled and time required prohibits a face to face review by Nottinghamshire.

4.3. The purpose of reviewing care home placements

The purpose of reviewing a care home placement is to consider whether it is the most appropriate way of meeting the long term needs of the service user. The reviewing officer needs to detemine whether the placement meets the outcomes in the support plan and offers choice and flexibility for the service user. The review should include the service user and any relatives they wish to be present, a representative of the home and any other appropriate person, for example, an independent advocate. The review should include consideration of:

- The existing support plan and outcomes
- Whether the resident's care plan clearly reflects the outcomes identified in the support plan.
- Whether care is provided at an appropriate level for the resident's needs
- Whether the resident has the mental capacity to make the decision in question. For example, does the resident have the capacity to participate in the review, or to agree to the placement?
- Whether there is an authorised Deprivation of Liberty safeguard in place. If so, the reviewing officer needs to check to see there is an allocated worker in a district team. If there is no allocated worker, the reviewing officer needs to take into account any conditions attached to the Deprivation of Liberty as part of the review.
- Whether the care home manager has taken appropriate action regarding any deprivation of liberty concerns arising from a resident's lack of capacity.
- Consideration should also be given to reviewing the entitlement of residents under section 117 of the Mental Health Act 1983. Where a resident is in receipt of section 117 aftercare and is exempt from contributions because of this, staff should review their entitlement to make sure that they are still eligible.

4.4. Before the review

In preparation for the review the preparation for review form (SDS/CHPR) can be sent to the resident along with standard letter SDS/CHRLETSU. Standard letter (SDS/CHLET) should be sent to any relatives or friends who are involved with the resident's care.

Reports should also be obtained from providers and other professionals.

4.5. Outcome of the review

Following the review a copy of the community care Review and support plan and letter SDS/CHRLETR must be sent to the service user.

If the service user is funding their own care, reviewing officers should ensure that they are given information about Paying for Care.

4.6. Quality assurance reviews

Quality assurance reviews are undertaken by a range of staff, including quality monitoring officers. Quality assurance audits are completed for each service provider annually. This work is led by quality monitoring officers and by the Market Development and Care Standards Team.

Reviewing officers should complete form CH/QMF – Care Homes following reviews at a care home if they identify any areas of concern during the review relating to generic care issues or to highlight good practice. The completed form must be sent to the Market Development and Care Standards Team (pmm@nottscc.gov.uk) where it will be forwarded onto the relevant quality monitoring officer. All fieldwork staff who visit care homes must also use this form if they have any general concerns about the quality of care or want to highlight any areas of good practice. This will help quality monitoring officers to pull together information relating to particular care homes, about possible problems and about good practice. Please note that quality monitoring officers cannot respond to concerns about care relating to individual service users, only to generic issues within the home.

The information from quality assurance reviews should form part of a service user's review.

For more information about the management of quality assurrance issues please refer to the Home Care Quality Monitoring Framework.

5. REVIEWING PROFESSIONAL SUPPORT

This staff guidance should be applied where professional support is the only service or part of a package of support. For a definition of professional support see, the guidance on Assessment, Support Planning and Personal Budgets, (Appendix 1: Guidance for staff on counting and monitoring professional support within Framework).

6. REVIEWING THE OUTCOME OF OT SPECIALIST ASSESSMENTS

See: Occupational Therapy – guidelines for assessment.

7. RECORDING THE REVIEW

Reviews must be recorded in Framework using the Review – Community Based Services episode for service users whose care is delivered in the community, or Review – Long Term Care for service users in long term care. This is regardless of review type, and includes telephone reviews and reviews by surgery or correspondence.

Within the review episodes is the mandatory review form:

- Community Care Review and Support Pan (mandatory)

The following optional forms are for use when setting up a Direct Payment:

- Direct Payment Agreement and Setup
- Pre-Payment Card Terms and Conditions

The episodes also contain a number of forms that can be used to request a variety of services, including:

- Home Care Request
- Day Service Support Needs Matrix
- Supported Living Referral Form
- Telecare Request
- Transport Eligibility Assessment

There are a number of other optional forms available within the review episodes to assist with other aspects of the service user's care, including risk management and finances.

Following review eligible service users will need a future review scheduling, typically after 12 months (following any initial review that may take place). However, workers will need to ensure that multiple reviews are not created. If a review already exists, then it either has to be closed down or re-scheduled (contact your Business Systems Support Officer for support on how to do this) or there is no need to add another one.

Attention must be paid to the quality of the case recording – see the Case Recording Policy. It is particularly important that the evidence recorded in the review relates to the decision about eligibility.

8. SCHEDULING FUTURE REVIEWS

Reviews should be 'proportionate' to the situation and reflect Departmental priorities in targeting staff resources at the most vulnerable. Priority for reviews, including for people living in residential care, has been established as follows.

8.1. Annual face to face reviews

Priority for face to face reviews must be given to service users whose needs are defined as "complex" or who are assessed as particularly vulnerable or at high risk. As all service users who are eligible for and in receipt of social care support are likely to be vulnerable in some way, the following factors should be taken into account:

- A high cost personal budget is likely to indicate a degree of complexity.
- Previous safeguarding alerts and investigations. An annual, or more frequent, review of the personal budget must be undertaken if the service user is likely to stay in contact with people or situations that have already resulted in safeguarding alerts and investigations. Additional reviews may also be required if indicated in the safeguarding plan.

- Multiple teams or agencies are involved with the service user. This indicates that co-ordination of support may be required and this may be best done through a face to face meeting; unless the service user is subject to, for example, the Care Programme Approach or Deprivation of Liberty safeguards where reviews are already mandatory.
- Other income strands may also indicate a degree of complexity, for example payment from the Independent Living Fund or continuing healthcare funding.
- The service user lacks mental capacity and has no friends or family to act in their best interests.
- Where a service user is not regularly seen by professional carers or other professionals and appears to avoid contact with caring and statutory agencies
- Where a service user has a personal assistant who is a family member.
- The assessor/team manager considers that a face to face review is needed for any other reason, for example, complex health/social issues.

8.2. Reviews by telephone, letter or surgery

The following circumstances may indicate that a telephone review/letter or review at a surgery can be undertaken:

- **Single service** - where a service user only has one managed service, such as day care or a homecare package. The review can be completed by telephone if other sources of information are readily available to the reviewer, for example, current information from the homecare agency, which is consistent with the information from the service user and/or carer. If the service user attends a day service, consideration can be given to holding a reviewing surgery in that location to undertake a number of reviews at the same time. This can also be considered for people living in residential care.
- **Long standing personal budgets** - where a service user has had the same personal budget either as a managed service or as a direct payment for more than one year with no changes anticipated to eligibility or support. This would apply where several services are in place or the support package is relatively high cost.
- **Residential placements** – where none of the indicators for a face to face review exist; the placement is considered to be stable and well supported; a face to face or surgery review has taken place the previous year; a trusted relative is available to consult. In this situation the reviewing officer MUST contact the relevant local authority to ask about the quality of the care home.

During a surgery the reviewing officer will undertake a number of reviews at a designated home, which will include meeting the resident and looking at their care plan.

8.3. Making a decision about level/type of future review

The decision about the frequency and type of future review can only be made on the evidence available at the time. Practitioners must make an informed and reasonable professional judgement on a case by case basis and provide evidence to support their recommendation. Where there are doubts about the best type of future review the practitioner must consult with their manager. The proposed type of next review and the reaons for this decision must be recorded in the "Agreement of support plan (signatures)" section of the community care review and support plan.

Methods of review other than face to face should be considered for the majority of situations where support arrangements are assessed as stable and safe.

Consideration must be given to undertaking a face to face review every other year with service users who meet the criteria for a telephone/clinic review.

The future review must be scheduled in Framework.

9. APPENDIX 1 - CHECKLIST FOR REVIEWING PERSONAL BUDGETS, DIRECT PAYMENTS AND CARERS SUPPORT

Personal Budgets
✓ Check Framework to see if another worker is involved in the case
✓ Send out standard letter "SDS Introduction to review" to service user.
✓ Demonstrate a partnership approach across agencies, with the service user and their family and friends, if they choose to involve them
✓ Complete/update the Community Care Review and Support Plan
✓ Check the eligibility banding and change if necessary
✓ Check the schedule and cost of all existing support/activity, including: regular breaks that the carer received previously and sitting services or day services for the service user
✓ Check to see if any minor amendments have been made to the support package in the last 12 months without a review. Ensure the support plan accurately reflects the current package of care by adding any new costs and removing any that have ceased.
✓ Find out the cost of support to the service user using the Social Care Directory (if new support) or by looking at the package details on the front screen of Framework and record in the support plan
✓ Ensure the support plan is cost effective, within budget and authorised by a team manager or panel
✓ Complete a referral for a financial assessment in Framework to ensure a correct invoice for the personal budget

✓ Establish whether the outcomes identified in the support plan are being met through current arrangements
✓ Support people to review their personal goals and consider what changes, if any, should be made to the support plan.
✓ Ensure that the risk assessment recorded in the support plan is up to date and identify any further action that needs to be taken to address issues relating to risk
✓ Support people to strengthen their informal support networks by the provision of appropriate information and advice on available community resources
✓ Check data quality on Framework and update information if necessary
✓ Schedule a future review date on Framework
Direct Payments
✓ **Always** review the Direct Payment Agreement andf Set Up document (ACM/39)
Carers
✓ Check whether a carers' assessment is in place and if a carers' review has been scheduled. If so, bring forward the carer's review to coincide with the service user's review. If not, complete Part A of the assessment and, if the carer is providing regular and substantial care, Part B
✓ Complete a young carers' assessment if an unpaid carer under 18 is identified within a review. An outcome of the review should be to provide support to the parent (or grandparent) so that the young person is not conducting care that is inappropriate for their age.